FILE COPY

IDAHO DEPARTMENT OF
# HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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PHONE: (208) 334-6626
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December 8, 2009

Ferren Weeks
Yellowstone Group Home #4 Hollow
560 West Sunnyside
Idaho Falls, ID 83401

RE: Yellowstone Group Home #4 Hollow, provider #13G066

Dear Mr. Weeks:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #4 Hollow, which was conducted on December 3, 2009.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/mlw
Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G066 | A. BUILDING _____ B. WING _____ | 12/03/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| YELLOWSTONE GROUP HOME #4 HOLLOW | 370 HOLLOW DRIVE IDAHO FALLS, ID 83402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 000 | INITIAL COMMENTS<br><br>Yellowstone Group Homes #4 - Hollow, is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation.<br><br>The survey was conducted by:<br>Jim Troutfetter, QMRP, Team Lead<br>Michael Case, LSW, QMRP | W 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

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|---|---|---|---|---|
| M 000 | 16.03.11 Initial Comments<br><br>Yellowstone Group Home #4, Hollow is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR)."<br><br>The survey was conducted by:<br>Jim Troutfetter, Team Lead<br>Michael Case, LSW, QMRP | M 000 | | |

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE